Key Points

FUNDING OF HOSPITAL CARE

- There are currently 31 acute care hospitals in Connecticut:
  - all but one are nonprofits – Essent/Sharon Hospital is for profit;
  - four have religious affiliations;
  - 18 are teaching hospitals;
  - most of the larger hospitals are along major interstate highways; and
  - New Britain and Bradley will merge October 1, but maintain separate campuses.

- Connecticut has comparatively high per capita health care costs, but spends a lower percentage of health care dollars on hospitals than the nationwide average.

- Total FY 05 net operating revenue, after adjustments, for all hospitals was approximately $6.36 billion, about a seven percent increase over FY 04. The contributing payer mix was:
  - 49 percent non-government;
  - 41 percent Medicare;
  - 9 percent Medicaid and other state medical assistance; and
  - about 1 percent uninsured and other.

- About 57 percent of statewide hospital adjusted net revenue comes from payments for inpatient care.

- Hospitals negotiate with private insurers and managed care companies on what they will pay. Typically the payments are a percentage discount off hospital charges.

- Medicare uses a prospective payment system. The federal Centers for Medicare and Medicaid Services set rates based on diagnostically related groups, which considers acuity.

- Connecticut's family Medicaid population is served by four managed care organizations (MCOs) under contract with the Department of Social Services. DSS establishes rates with the MCOs annually; the MCOs negotiate what they will pay hospitals.

- Connecticut's adult Medicaid population is served under fee-for-service. DSS establishes the rates it will pay hospitals, based on a targeted discharge rate. The rates were last rebased in 2001 to consider hospital costs in 1999. The state Medicaid rates do not consider acuity.

Key Points

- There is considerable variation in the rates paid to hospitals, but especially in the Medicaid rates.

- Depending on the payer source, the payments may or may not cover a hospital's costs. The following is the statewide ratio of payment to costs for the three large payer groups for FY 05:

  - non-government (i.e., private insurers, HMOs) have a ratio of 1.2;
  - Medicare has a ratio of 0.97; and
  - Medicaid has a ratio of .73.

- Given these ratios, a hospital's payer mix is important to its financial condition. Based on inpatient discharges, four hospitals had Medicaid populations higher than 20 percent, and one served more than 40 percent Medicaid.

- The cost of all uncompensated care -- including government underpayments – as a percentage of hospital operating expenses has increased from 6.9 percent in FY 03 to 7.6 percent in FY 05. More than half of the uncompensated care is due to government underpayments.

- Populations covered by Medicare and Medicaid are typically heavier users of hospital services – Medicare patients had 32 inpatient hospital stays per 100, while Medicaid had 35.4; SAGA had 30.8 and Medicaid Managed Care had 12 per 100. This compares with 6.5 stays per 100 people with private insurance.

- The average length of stay (ALOS) varies by population and by hospital. The average ALOS statewide for FY 05 was 4.8 days. The average ALOS by population was:

  - 3.7 days for private insured patients;
  - 5.9 days for Medicare;
  - 6.4 days for Medicaid fee-for-service;
  - 4.0 days for Medicaid managed care; and
  - 5.7 days for SAGA.

- For FY 05, 21 hospitals had positive operating margins and 10 had negative margins. Two hospitals had negative operating margins of more than 10 percent. Five of the 10 had negative operating margins for three consecutive years (FY 03 through FY 05).

- Many of the hospitals that are in financial distress have many of the problem indicators examined by PRI, such as high Medicaid populations, high number of full-time equivalent employees and expenses for discharges (adjusted for acuity), and low payment to cost ratios.